EYE PHYSICIANS OF AUSTIN
Advanced Eye Care

Authorization to Use or Disclose My Health Information

Patient name: _____

Date of birth: _____ EPA Record Number: _____

I. My Authorization

You may use or disclose the following health care information:

☐ All my health information maintained by you

☐ All my health information for the following date(s) or condition: _____

☐ Other: _____

*If you request a copy of your health information, we may charge a reasonable fee. If a fee applies, an estimated amount will be communicated at the time of your request.

If my medical records include information regarding HIV/AIDS, drug abuse, alcoholism or alcohol abuse or psychological/psychiatric conditions, I DO _____DO NOT_____ authorize the release of this information.

Information to be released [ ] from **[ ]** to _____

Address: _____

Fax Number: _____

[ ] from **[ ]** to Eye Physicians of Austin, PA
5011 Burnet Road, Austin, TX 78756
(512) 583-2020 Fax: (512) 744-2020

☐ **Paper copy** ☐ **Fax** ☐ **Electronic copy:** ☐ **CD or** ☐ **Email** _____

Reason for this authorization: _____

This authorization is good for ninety days.

Secure Communication: Note that regular email and some fax transmission methods are not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not designate email or fax as your preferred method of disclosure if this is of concern to you.

II. My Rights

I understand I do not have to sign this authorization in order to receive treatment. However, I may be required to sign this authorization form:

- To take part in a research study; or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization at any time, in writing, sent to the address provided above. If I do, it will not affect any actions already taken by Eye Physicians of Austin, PA based upon this authorization; uses and disclosures already made cannot be taken back. I may not be able to revoke this authorization if its purpose was to obtain insurance. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

I may receive a copy of this authorization upon my request. A copy of this authorization is as valid as the original.

_____ _____ _____ _____
Patient or legally authorized individual signature | Date | EPA Witness | Date

_____ _____
Printed name if signed on behalf of the patient | Relationship & Authority (parent, legal guardian, personal representative, etc.)